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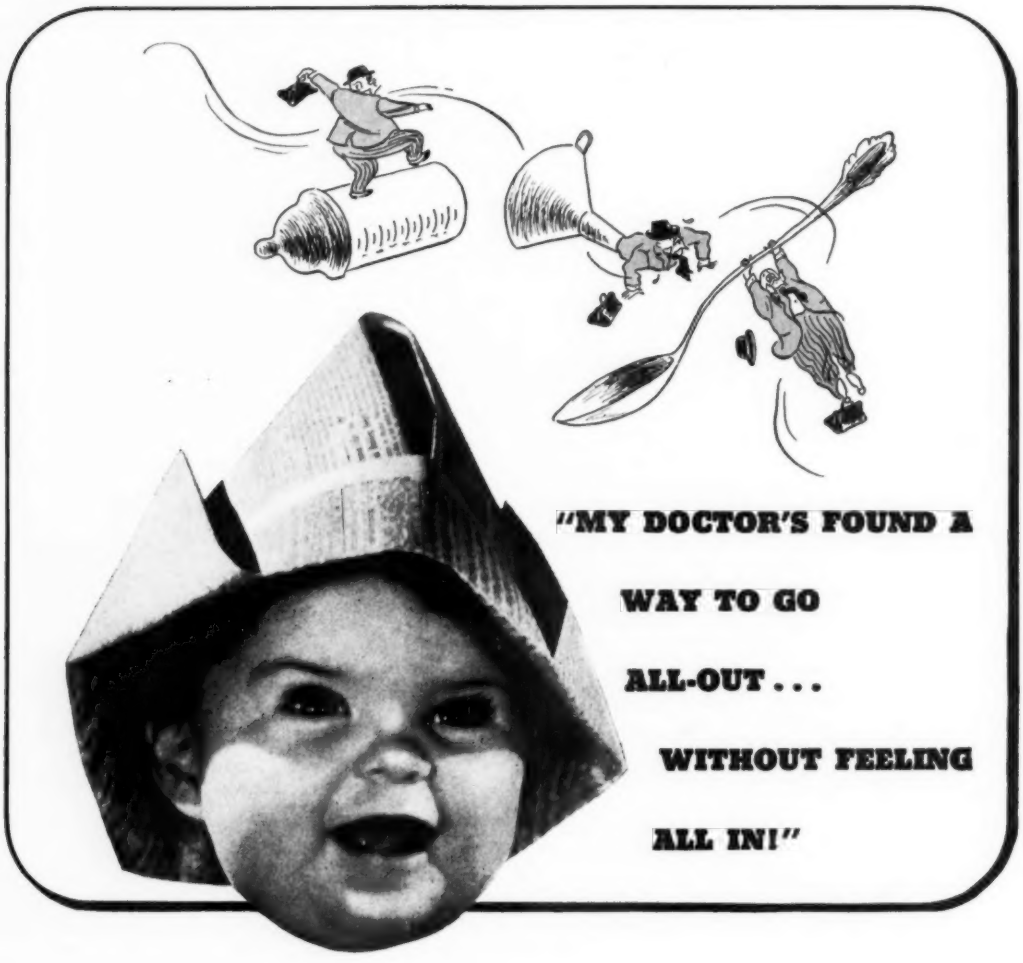

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Rheumatic Fever

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For a long time rheumatism in children was not thought to be a common occurrence in this section. However, when we became more conscious of it, the number of cases seen has gradually grown; and now this disease is one of the more common ones seen in the wards and out-patient department of Roper Hospital. For this reason we felt that a ten-year survey would probably be worthwhile.

In discussing this subject, we will use the terms "rheumatic fever" or "rheumatism," admittedly poor titles but still probably the best to express the condition under consideration.

This disease is endemic and no area is entirely free of its ravages, but it appears to be more prevalent in urban communities, in the temperate latitudes throughout the world; cold and damp climates, with sudden wide fluctuations of temperatures, apparently act in the role of predisposing factors. Overcrowding and extreme poverty are not prime factors. However, these states may be the cause of lowered resistance.

Cohen estimates that twenty in every thousand persons are affected with heart disease in the adult population in the United States. Church found that 3 to 7 per cent of all hospital admissions have this disease.

In recent years there seems to be an increase in the importance attributed to the role which heredity plays in this disease. In one group this trait was prevalent in 24% of the cases.

There has been much work and more discussion with divided opinions concerning the etiology of acute rheumatism. Coburn thinks that heredity and environment combine to produce persons who do not handle respiratory infections with hemolytic streptococci in a normal manner. Their immune response to primary infection is inadequate, with the result that the cells of the reticulo-endothelial system become sensitized. Subsequent contact of antigen and antibody within the sensitized cell gives rise to an abnormal reaction which leads to the characteristic inflammation of rheumatism. However, the streptococcus, primary or secondary, as the etiological agent, is steadily gaining ground, and it is inconsequential whether this state is produced by allergy or other factors — the end results have much in common. Nevertheless, it is interesting to refresh our thoughts with the facts which may result from indwelling streptococcal infections or to speculate about the damage to the epithelium of the respiratory system by certain virus infections which apparently need only an open door to invade and involve certain mesodermal structures which afford more suitable soil for their rendezvous; but why rheumatic attacks develop after such infections in some cases and do not in others, remains a vexing question. The lesions of rheumatism have one fundamental basic structure whose character may vary with the anatomical site in which it occurs but which, nevertheless, represents the essential relation of the tissues to the rheumatic virus. The lesion is the so called rheumatic nodule. Swift has pointed out that there are two main types of lesions in rheumatism — the one proliferative, the other exudative.

There is always some correlation of symptoms to the lesions in acute rheumatism. Varied as are the lesions of this disease, they have the same stamp of hallmark, but the anatomical differences produce marked divergences in the symptomology. The joints are highly vascular and contain a large amount of structural tissue which is well supplied and which resists, on account of its anatomical structure, expansion; and when exudation takes place, there is marked pain, heat and edema.

As the records will show, there was little reference to the subcutaneous nodes in this series — probably due to the lack of meticulous care while doing the physical examination. Because of the scarcity of connective tissue and the small size of the blood vessels in the myocardium, the lesions in the early stage are small and seldom very formidable but are readily manifested in the electrocardiograph tracing. As a later manifestation, the valve may show the havoc wrought by this type of inflam-

mation, with its fibrotic displacement and its resultant deformity which is responsible for the various types of murmurs and for the mechanical cardiac defects. The symptoms of chorea and the lesions which are supposed to be vascular, do not follow the same definite pattern, and the structural damage here is not commensurate with the severity of the symptoms.

Apparently the valves of the heart suffer more than other structures and soon show there is some tell-tale evidence; for when the mechanism of the heart becomes disrupted or fouled, there soon will be discernible discrepancies in rate, rhythm and hydrodynamics which may or may not lead to cardiac insufficiency or failure.

Carey Combs studied 97 cases of rheumatic valvular disease and found the mitral valve involved in all of these cases — the aortic valve involved in only 57, the tricuspid in 35, and the pulmonary in 2. Therefore, it is easy to understand why the mitral area is the commonest site for both systolic and presystolic murmurs.

The early systolic murmur heard in the mitral area is due to myocardial failure, which causes stretching of the auriculo-ventricular ring and a reverse flow of blood into the auricle, producing a soft systolic murmur — while the presystolic is produced on an entirely different basis. Here the normal function of valves is slowly disrupted by the infection in their structure and attachments; and as time goes on, the damage becomes more and more marked — flexibility is lost to adhesions and deformities, which results in various types of diastolic sound. Murmurs heard in the aortic area are due to a crippling of the cusps. This destroys their harmonious action, prevents their normal closure and leads to abnormal sounds.

If the first attack does not leave any clinical evidence of heart damage, and should there be a subsequent attack, this organ may escape the maiming so common in this disease. But when this tell-tale damage is quite evident during the first attack, usually each subsequent one will register new evidences of destruction which is fairly easily demonstrated by physical examination and laboratory procedures. Of the latter, the electrocardiogram and sedimentation rate appear to be of most value. In the acute case the damage to the myocardium is believed to be due to a diffusible toxin which acts on the muscle cells and thereby causes ventricular failure. As time goes on the cardiac reserve is depleted, which may be hastened by the defective mechanism caused by this disease, and heart failure of one type or another will result.

During the past ten years there have been 43 cases of rheumatism admitted to the Pediatric Department of Roper Hospital. Of this number, 34 had one admission; seven, two, one three; one, four; and one, six admissions. The number of hospital days averaged 33½ days per patient, varying from one day terminated by death, to 145 days for another patient. Thirty-one of these patients were negroes and twelve, white. Twenty-five of the cases were females, and the remaining eighteen, males. These patients had an average age of 8.1 years on admission; the youngest being three years old and the o'dest, thirteen years of age.

Of symptoms recorded on admission, fever is most frequent, being the chief complaint in twenty-nine cases. Pain in joints, limbs or extremities is recorded in twenty-one instances, and in sixteen cases swelling of the parts involved was noted. Abdominal pain was present in twelve cases, one of which was diagnosed as acute appendicitis and on operation a post-operative diagnosis of mesenteric lymphadenitis was made. Following this, the child developed typical rheumatism. Five complained of pain in the region of the heart and three of palpitation. Sore throat was complained of by five and a cough, dry and hacking in most cases, by eight. Six cases had anorexia; five, nausea and vomiting; and five, headaches. Two had had night sweats, and nose b'eeds, twitching, ear infection were complained of in one case each.

On admission, with the exception of two cases, all showed cardiac involvement ranging from a systolic murmur at the apex to pronounced myocarditis and pericarditis.

In 31 cases a systolic murmur was heard at the apex which was transmitted to the left axilla in eight instances, to the back six times, and the murmur was also heard over the entire precordium in thirteen of these cases. A diastolic or presystolic murmur was heard at the apex in ten occasions. A systolic thrill at the apex was noted five times and a presystolic thrill once. A loud to and fro murmur at the apex was described in one case. A systolic murmur over the entire precordium without localizing area was mentioned twice and also a systolic murmur along the left sternal border was noted twice. A systolic murmur at the pulmonic area, different from that at the apex, was heard in four of the cases. Mentioned once each were a loud to and fro murmur at the base, a systolic murmur at the base, an aortic diastolic murmur, a systolic murmur at the aortic area with an associated thrill with the murmur being transmitted to the great vessels of the neck and also being heard over the femoral arteries, an aortic diastolic murmur and a diastolic murmur at the pulmonic area which was transmitted to the back. Gallop rhythm was observed to be present on four occasions and P_2 greater than A_2 four times. A pleuro-pericardial friction rub was present in one case, and total irregularity of the heart rhythm was noted twice. In 49% of the cases it was noted that the tonsils were abnormal to some degree.

During hospitalization the range of temperature readings in these cases was from a low of 96° F. to a high of 108° F. The latter reading recorded

just prior to death in one case. The average low temperature was 97.6°, while the average high temperature was 101.95°. Pulse recordings ranged from 50 to 165; the average low was 82 and the average high was 136 beats per minute. For blood pressure an average of 109 mm. hg. systolic, and 70 diastolic is found. The white blood count averaged 12,600 per cu. mm. with an average low of 9,650 and an average high of 15,400. The red blood count showed an average of 3,897,500. Hemoglobin determinations average 10.9 gm. The sedimentation rate ranged from a low of 18 mm. per hour corrected (Wintrobe's Method) to a high of 36 mm. The average sedimentation rate on admission was 28 mm. per hour corrected. The Wassermann reaction was positive in only four cases. Sealed wet preparations for sickling of the red blood cells were done on eight cases and in only one of these was sickling present. In this case there were many sickled cells present immediately, and in three hours there was 100% sickling of the red blood cells.

In studying the past history of illness in these forty-three cases we find, as would be expected, two communicable childhood disease heading the list: measles in 42% of the forty cases on which information was available, and whooping cough in 40%. Tonsillitis is next in frequency with thirteen cases or 32%, and sore throat is reported in five other cases in which the tonsils may or may not have been involved. Tonsillectomies had been performed already in three of these cases, at some time prior to the present illness (six months to four years). Other diseases of the respiratory tract occur with some frequency: recurring colds, five cases; influenza, four; pneumonia, three; otitis media, two; bronchitis, one. Mumps is listed in eight cases. Worms, colitis, scarlet fever, twitching, and kidney trouble are reported in an insignificant number of cases. Two cases report cardiac symptoms as far back as can be remembered. In two other cases cardiac symptoms were noticeable for five years before the present illness. One case each reports symptoms for four years, three and one-half years, and two years. Cardiac symptoms noticeable for less than a year were reported by four, and for a month or shorter time by six. Difficult respiration and fatigability seemed to be the most common symptoms. Abdominal pain is mentioned three times and an undiagnosed febrile condition also occurs three times in past histories. (Malaria three times.) Arthritis is once reported. Fifteen per cent of cases reported no previous attack prior to present illness. Sixty-one per cent had suffered attacks for periods of one month to one year before present illness. In one case, attacks had been repeated for the past three and one-half years, and in another, attacks had recurred during the entire life of the child. (13 years.)

In approximately forty per cent of cases, both parents are reported as living and in good health, while twenty per cent report both parents and other children of the family as living and well. Sixty per cent have had deaths in the immediate family, or have sickness at present, or both. Heart disease, in two instances fatal, appears four times as affecting other members of the immediate families. Rheumatism is twice reported, once as the cause of grandfather's death, and once as having appeared in father as a child. Diarrhea, diabetes, asthma, and "female trouble" are each mentioned once as occurring in the immediate families. Pneumonia, "stroke," and diphtheria are responsible for one death each.

The following addenda is a summary of the cases seen in the Rheumatic Fever Clinic since its inauguration in February, 1944, through August 1, 1944. This clinic, while primarily established to study and take care of patients with rheumatic manfestations, is also a diagnostic clinic and there have been several cases seen who did not have rheumatic fever or rheumatic heart disease. The clinic takes care of all cases referred to it from Charleston County and 6 surrounding counties but included in this series are several patients from portions of South Carolina residing outside of this area.

There have been 40 cases seen in the clinic since its beginning. Of these there were 32 in whom the diagnosis of rheumatic fever or heart disease was made. In 3, congenital heart disease was diagnosed and there were 5 cases which had various other diagnoses.

In the rheumatic group of 32 there were 24 negroes and 8 white patients. Of these there were 15 males and 17 females. The average age was 9.8 years and the youngest patients seen were 5 years old and the oldest 20. In citing the age incidence it should be remembered that when a person becomes 21 years of age he is no longer eligible for care under the program. Of these patients, 31 were seen in the clinic and there were 20 who were hospitalized. Nine have been sent to the convalescent home in Florence having reached the inactive stage during hospitalization.

There have been 22 cases of active rheumatic fever or heart disease and 10 inactive cases admitted to the clinic.

In summarizing the laboratory findings we find that the urinalysis was negative in 23 cases. Three showed 1 to 2 plus sugar, 4 showed a few pus cells and in one case an albumin of 2 plus was recorded. The average hemoglobin was 10.9 gms. per 100 c. c. (Haden Hausser) with a high of 15 gms. and a low of 7 gms. The average W. B. C. was 8,626.8 per cu. m. m. with a high of 21,300 and a low of 4,150. The average polymorpho-nuclear count 54% with a high of 87% and a low of 21%. In the 32 cases the Wassermann Reaction was positive once. There were 2 cases in which sickling of the R. B. C. was found to occur under reduced oxygen tension but

neither of these cases was thought to be a case of sickle cell anemia. The sedimentation rate done according to Wintrobe's method was found to average 19.6 m. m. per hour corrected with a high of 49 and low of 2 m. m. per hour. Seventeen stools were examined and one case of oxyuriasis was found.

X rays were taken for heart size on all patients and 18 were found to have enlargement of the heart to some degree. In 10 cases the heart was slightly enlarged, in 5 there was moderate cardiac enlargement and in 3, marked enlargement of the heart was reported.

Electrocardiographic tracings were also taken on all patients and in 18 cases were reported normal. In the other cases a delayed A-V conduction or prolonged P-R interval was reported 6 times. There were 8 instances of sinus tacchycardia. Left ventricular preponderance was noted 3 times and right ventricular preponderance was found in 3 cases. There was a sinus arrythmia present in 3 of the cases. Elevated take off of S. T. segment was noted once and in one instance each ventricular extrasystoles, auricular extrasystoles, auricular flutter and 1st degree heart block were noted.

At the present time according to the records we have 23 patients whom we believe to be in the inactive phase of rheumatic fever and 8 who are in the active phase. One patient who was in the active phase when seen in the clinic refused to cooperate and his present status is not known. There are at present 5 active cases in Roper Hospital and 9 inactive cases recuperating at the Convalescent Home in Florence. The remaining 3 active cases are being treated at home under the supervision of our medical social worker.

Present day treatment of acute rheumatic fever or rheumatism may be divided into three phases: (1) Prophylaxis or preventive measures; (2) Care of the acutely active case; (3) Treatment of the non-active case.

Until we understand the nature and cause of rheumatic manifestations and realize that rheumatic fever is an infectious systemic disease which is more prevalent during childhood and the adolescent period than at any other decade of life, that the causative agent may be a hemolytic streptococcus which acts alone or in combination with other factors of unknown nature and the exact role played by this organism alone or in combination with other factors on the tissue of the susceptible host, we may be restrained to some extent in our efforts of prophylactic treatment of this disease. However, we do know that certain individuals are more susceptible to streptococcic infection, and that heredity may render some individuals more susceptible; that cold and damp climates with marked fluctuations in temperature, that over-crowding and under nourishment may act as predisposing factors; that there is also some association between upper respiratory infection with Group A hemolytic streptococcus and the onset of this disease, and that until we are endowed with more of the fundamental knowledge concerning these factors, our prophylactic treatment must of necessity be directed along such lines as maintaining the highest state of nutrition that it is possible under the circumstances, and that we make every effort to protect certain known groups from respiratory infection, see that there is no obstruction in the nasopharynx by hypertrophied tonsils and adenoidal tissue which would hinder normal aeration of the respiratory tract; that special emphasis should be placed on the prevention of the acute contagious and infectious diseases, that we should ever be mindful of the benefits which may be derived from a mild climate, sunshine and fresh air, and that certain drugs such as sulfonamides and sodium salicylates may be worth while agents as prophylactic measures.

The acutely active rheumatic fever patient is probably best cared for in a hospital where he can be properly isolated or in a suitable private home, for usually he is susceptible to most types of infections. Of course, bed comfort and efficient nursing care goes without saying. A generous well balanced diet and a nurse who has the tact to induce the patient to eat regardless of his desire for food, is most helpful. Nothing relieves the pain and gives the patient a better outlook than the administration of aspirin or sodium salicylate in sufficient dosage. The amount necessary for this purpose usually varies with the individual but large doses may be necessary to check activity. Sodium salicylate is the drug of choice. Research workers in this field believe that there is more benefit to be derived from its administration than the relief of pain. This is somewhat suggestive from its prophylactic value, however, we should not forget that large doses of this drug given intravenously may cause serious damage or poisoning. During the active phase and hospitalization, it is hard to overestimate the value and guidance which may be derived from laboratory studies. These procedures keep the door ajar and reveal to some extent a prospectus of the patients progress and may furnish the nucleus for intelligent treatment of this disease. A total and differential white blood count, hemoglobin, red count, sedimentation rate, electrocardiogram, vital capacity, salicylate level in blood are some of the more common procedures used.

Digitalis is of questionable value during the active phase of the disease, for many therapeutists claim that it is impossible to make a degenerating myocardial muscle respond to this drug. Nevertheless, when there is evidence of congestive failure and the patient has a normal sedimentation rate, digitalis may be used to advantage. Sulfa drugs are said to be contraindicated during the early active phase of this disease. Gaining the confidence of the child and the application of some childhood psychology may be important factors in obtaining co-

operation and prolonged physical restriction which is essential in the treatment of rheumatic fever, for complete bed rest and certainly restricted bed comfort may be necessary for many months.

After the rheumatic fever patient has reached the inactive phase of this disease we may try to outline or plan suitable activity for the individual case. In those cases where cardiac damage is not revealed, it is a simple procedure to have him gradually return to his activities or vocation in life, then recheck him at fairly frequent intervals to ascertain whether or not he is capable of maintaining this pace. It is always well to encourage the child to exercise to the limit of his capacity and to discourage parents and teachers from making a chronic invalid of him. However, when the rheumatic patient has demonstrable cardiac damage, he will succumb to a second attack un'ess he is given a certain amount of guidance and care and avoids, as far as possible, undue exposure to infection and we know that each succeeding attack will always add to the previous cardiac damage. In such cases the sulfonamides and salicylates have been used to some advantage as prophylactic agents which have apparently reduced the number of relapses in these types of patients. A small group of cases will require special care. Here vocational guidance and occupational training may be necessary for those with limited physical activities. Therefore, if we can assist the patient in evaluating his physical handicap and show him that it does not necessarily prevent him from reaching his objectives in life, and that security and happiness are within his grasp, we have gone a long way in our efforts to make him a productive useful citizen who is capable of taking his place in society.

*From Pediatric Department, Medical College of the State of South Carolina.

The Development and Interpretation of the Auscultatory Signs of Mitral Stenosis

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AND
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The diagnosis of stenosis of the mitral heart valve is usually stated to depend on the finding of a low pitched rumbling or occasionally blowing diastolic murmur, frequently "crescendo" in character and ending abruptly in an accentuated first heart sound, with maximum intensity near the apex of the heart. These criteria have usually proved to be a fairly accurate indication of the anatomical state of the mitral valve as found at autopsy. But as early as 1862 Austin Flint[1] pointed out their occasional inaccuracy in the presence of aortic valve insufficiency. In 1923 Wood and White[2] observed their occurrence in some greatly enlarged hearts with normal valves at autopsy.

Within the last few years attention has been called to their frequent occurrence in young individuals subject to rheumatic infection, but without gross deformity of the mitral valve at autopsy. Bland, White and Jones[3] in a study of the postmortem findings in a group of 100 young rheumatic fever patients found the anatomical lesion of mitral stenosis to be actually present in less than one-third of 68 cases in whom the clinical diagnosis had been made "on the basis of a rumbling mitral diastolic murmur (and of a blowing systolic murmur) best heard at the apex of the heart." The same authors[4] in a clinical study of 1000 rheumatic cases followed an average of 10 years from the onset of infection found that these signs, in addition to cardiac enlargement, subsequently disappeared in 8.3% of the series.

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The purpose of the present communication is twofold: (a) to describe the auscultatory findings in a small group of cases that were observed from the time when there was no definite evidence of valvular disease to the time when the classical signs of mitral stenosis were present, and (b) to attempt to set up more accurate standards for the diagnosis of mitral stenosis in young people.

In a review of the records of 225 cases of "potential rheumatic heart disease" and "rheumatic mitral insufficiency,"[5] we were struck with the necessity for being conservative in making the diagnosis of mitral stenosis in young people. In 10 of these cases, a rumbling apical "mid-diastolic" murmur, described on various occasions in each patient by experienced, conservative observers, was found subsequently to disappear and remain absent over a period of several years. Of these 10 cases, apical

systolic murmurs were originally heard in all, but these systolic murmurs persisted throughout the observation period in only 5. In two of the cases in which a mid-diastolic murmur disappeared, aortic insufficiency subsequently developed.

In 17 cases of the 225 a classical long, rough presystolic crescendo murmur ending in an accentuated first sound at the apex was heard. This murmur persisted from 6 months to 7 years in the various patients, and in no instance did it disappear after once having been heard. Therefore, it was left that a definite, final diagnosis of mitral stenosis could be made in these 17 patients. Only one of these died, and autopsy confirmed the diagnosis in this case. Looking into the earlier findings leading up to the classical findings of mitral stenosis beyond reasonable doubt, the following factors were apparent:

1. In 15 cases the apical systolic murmur of mitral insufficiency was the first finding.

2. In 12 cases, the finding of a rumbling mid-diastolic murmur preceded by months or a few years the appearance of the presystolic crescendo.

3. In 5 cases, the presystolic crescendo appeared without a preceding mid diastolic murmur having been heard.

4. In 4 cases the murmur of mitral stenosis appeared with no apical systolic murmur having previously been heard. In 2 of these, apical systolic murmurs appeared for the first time coincidently with the presystolic murmur.

5. In 2 cases, a previously present apical systolic murmur was found to disappear after the finding of an apical presystolic murmur.

For many years certain accessory signs have been described as suggestive of or helpful in the diagnosis of mitral stenosis. These are: accentuation of the first heart sound at the apex, accentuation with or without reduplication of the pulmonic second sound, apical systolic murmurs, and the apical "third heart sound." As a measure of the reliability of these accessory signs in anticipating a definite diagnosis of mitral stenosis, the frequency of their occurrence before the definite diagnosis in the 17 cases is compared in Table 1 with their occurrence in 83 other cases of the series who were followed 10 years or longer, but who did not in this time show definite evidence of organic valvular disease.

TABLE 1

	Patients with classical signs of mitral stenosis %	Patients followed 10 years without valvular disease %
Accentuated apical 1st sound	88	52
Accentuated pulmonic 2nd sound	82	54
Apical systolic murmur	94	89
Apical third heart sound	35	42

From this comparison it appears that there was a definitely higher incidence of accentuated apical first sound and pulmonic second sound among the patients who later developed classical signs of mitral stenosis, but the difference in incidence between the two groups is not sufficiently impressive to be of practical help, except to inspire the observer to seek more diligently for more definite evidence of mitral stenosis.

Summary and Conclusions

During a study of 225 cases of "potential rheumatic heart disease" and "rheumatic mitral insufficiency" followed closely over a period of 5 to 23 years, the auscultatory findings leading up to a final diagnosis of mitral stenosis in 17 cases were observed and described. In 12 of these cases the finding of a rumbling apical mid-diastolic murmur preceded by months or years the appearance of the classical presystolic crescendo murmur of mitral stenosis. In 10 other cases of the 225, a similar mid-diastolic murmur was subsequently found to disappear. The appearance of accentuation of the apical first heart sound and of the pulmonic second sound in rheumatic patients should stimulate the clinician to search more diligently for definite signs of valvular disease, but of themselves are of little practical help in forecasting the development of mitral stenosis. The presence of apical systolic murmurs of slight intensity and of apical third heart sounds seem to have no practical implications.

The results of the study suggest that in adolescent and young adult rheumatic patients a definite diagnosis of mitral stenosis should be made only on the finding of a long rumbling presystolic apical crescendo murmur ending in an accentuated first heart sound. The diagnosis may be suspected on the finding of definite apical mid-diastolic murmurs, but with the expectation that approximately half of these murmurs will disappear with further observation.

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The Rheumatic Fever Program in S. C.

G. S. T. PEEPLES, M.D., COLUMBIA, S. C.

The Author:
Dr. Peeples is the Director of the Crippled Children Division of the S. C. State Board of Health. He is a graduate of the Medical College of the State of S. C. (1926).

I. Administration

The Rheumatic Fever Program is administered under the direction of the Crippled Children Division of the State Board of Health.

II. Advisory Committee

The Advisory Committee for the Crippled Children Program is the Advisory Committee for the Rheumatic Fever Program: namely, Dr. J. Warren White, one of our district orthopedic surgeons and Chief Surgeon of the Shriners' Hospital; Dr. William Weston, Jr., pediatrician, Columbia, South Carolina; Mr. F O. Bates, Superintendent of Roper Hospital, Charleston, South Carolina; Mr. P. G. Sherer, Superintendent of the Vocational-Rehabilitation Department, State Department of Education; and Dr. Roger Doughty, surgeon, Columbia, South Carolina.

III. Eligibility

Children under the age of twenty-one with heart disease or conditions (such as Rheumatic Fever) leading to heart disease are eligible for care.

(a) Diagnostic Services—

Any child having or suspected of having heart disease or conditions leading to heart disease is eligible to attend the diagnostic clinic. This may be on a voluntary basis or by referral through physicians, health departments, or other agencies; provided, that application is made through The State Board of Health so that proper registry may be obtained; and, provided, that an appointment is made with the physician in charge of the rheumatic fever clinic by the Division for Crippled Children of the State Board of Health.

The diagnostic clinic is attended by two pediatricians, a cardiologist, medical-social worker and at least one nurse. A clinic fee of $1.50 is paid on each case which includes all laboratory procedures, in cluding fluoroscopy and cardiography, but does not include X-ray plates. X-ray films are paid for on the basis of $1.50 to $3.00, according to the size of the film. Diagnostic clinics are held each Thursday morning at the Alumni Building, Medical College, Charleston, South Carolina.

(b) Treatment Services—

Any case recommended by the rheumatic fever diagnostic clinic is eligible for treatment including hospital and/or convalescent care; provided, they are medically needy and reside within the geographic scope of the program. The diagnostic clinic physicians are the hospital attending physicians.

IV. Geographic Scope of Program

The area to be served is necessarily small due to two main reasons: (1) This is a research program to determine and estimate the need of such services on a state-wide basis; to determine methods of making an early diagnosis on the type of case presenting itself in this climate. (2) The finances are limited, which automatically limits the area to be served.

The area served is limited to Charleston, Georgetown, Horry, Berkeley, Dorchester, Colleton and Florence Counties. This area covers 6,591 square miles. The population is 215,508 whites and 200,112 colored. The population statistics are based on the No. 2 War Ration Books in use October 31, 1943.

Each County in the area has a full-time public health unit. The area is served by one medical-social worker and thirty-three county health nurses. In addition, there are social workers operating under the immediate direction of the State Welfare Department who cooperate, but are not under any direct control of the State Board of Health.

V. Plans for Providing Care

(a) For the child who is acutely ill—

The child who is acutely ill is hospitalized; provided, he is medically needy. Hospitalization is paid for on an all-inclusive rate, which is the same sum used for all crippled children. The only hospital serving under this plan is the Roper Hospital located at Charleston. The McLeod Infirmary at Florence, S. C. will be used should an emergency arise at the Convalescent Home.

(b) For the child who needs prolonged rest in bed—

The child who needs prolonged rest in bed can be either transported to the Convalescent Home in Florence, placed in one of the foster homes located at Charleston or it may be sent home, if environmental conditions warrant. These decisions are made by the attending physician in consultation with the medical-social worker. Foster homes are paid at the rate of $1.50 per day, per case. The Convalescent Home $2.00 per day, per case.

VI. Follow-up Care

Follow-up care is provided through our medical-social worker, our district orthopedic nurses and county health nurses. Proper travel is allowed for this service and also for the pediatricians to make as frequent visits as is necessary to the convalescent, fostor, or private homes, whever the case may be.

VII. Transportation Arrangements

Transportation is usually provided by the medical-social worker, the county or district nurses, the family and welfare agencies. Travel is reimbursed on the basis of five cents per mile.

VIII. The South Carolina Convalescent Home (Management)

(Located at Florence, S. C.)

(a) Professional Staff—

There shall be created a professional staff to be known as consultants, which will consist of a pediatrician, orthopedist, general surgeon and internist. This staff will be on a part-time basis. This staff shall be selected by the Executive Committee of the State Board of Health. The operating staff on the Convalescent Home shall consist of a supervisor and such other administrative and nursing personnel as may be considered necessary by the subcommittee of the Executive Committee consisting of Dr. W. R. Mead, Dr. W. L. Pressly and Dr. W. R. Wallace.

The professional staff consists of one pediatrician, part time; one orthopedist, part-time; four registered nurses; seven practical nurses; one physical-therapist; and one laboratory technician, part-time. The laboratory work is confined to total and differential blood counts, blood sedimentation rates and routine urinalyses. Arrangements are being made to include electrocardiographs (EKG). It is considered essential to provide this type of laboratory service especially if the attending physician is to determine when a rheumatic fever case, for example, has reached the inactive phase of the disease. According to the best of authorities the physician cannot fearlessly and intelligently discharge or plan the activities of a rheumatic fever victim without the aid of these simple laboratory procedures.

(b) Admission—

After a case has visited a diagnostic clinic and the attending orthopedic surgeon deems it advisable that convalescent care be necessary, the surgeon will make a written request to the Division for Crippled Children for such convalescent care. This request must state the length of stay as in his judgment is necessary but in no event to exceed ninety days. Upon receipt of this request in the division central office, if the case is properly registered, convalescent care will be authorized by the Director of the Division on an approved form. Provided, however, that the special provision hereinafter made for cardiac cases is applied. The admission of applicants to the Crippled Children's Home shall be governed by all requirements, rules and regulations of admission of crippled children to the general crippled children program except as hereinafter provided.

(c) Incurables and Mental Deficiencies—

No incurable or severe mental deficiency cases are acceptable for admission.

(d) Cardiac Cases—

The application for admission of cardiac cases must be made on prescribed forms. The application must be approved by a certified pediatrician in the district from which the child comes. Provided, that the rules and regulations requiring that all applicants must attend a crippled children's clinic shall not apply to cardiac cases, who will otherwise meet all requirements of law, rules and regulations governing the admission of crippled children for State Aid.

(e) Length of Convalescent Care—

No authorization for convalescent care shall be granted to exceed ninety days except upon written application of the Medical Consulting Staff who shall make reasonable explanation to the Director of the Division for Crippled Children of the need for such further care.

(f) Contagious Diseases—

No child shall be admitted with an acute illness or a contagious or infectious disease. Provided that, in the case of acute rheumatic heart cases a certificate signed by a certified pediatrician stating that the case is not dangerous to other ward cases shall accompany the application.

(g) Acute Illness—

In case of an acute illness, whether medical or surgical, the patient shall be immediately transferred to the McLeod Infirmary for appropriate treatment. The McLeod Infirmary will be remunerated on the same basis as for any crippled child. Provided, that the referring orthopedic surgeon, or pediatrician, be immediately notified and the final disposition of the case be determined after this consultation, and if practicable the child shall be transferred back to the hospital in the district from which it came.

(h) Responsibility of Referring Physician—

The admission of an applicant to the convalescent home shall not be construed to mean that the referring orthopedic surgeon, or pediatrician is discharged from the case. The referring surgeon or pediatrician shall have the right and authority to request and outline a definite type of treatment such as massage, muscle re-education, medical diathermy, hydrotherapy or other physical treatment. Should any material changes in the treatment outlined by the referring physician become necessary in the judgment of the attending staff, then, the referring physician must be consulted.

(i) These rules and regulations may be amended from time to time by the Executive Committee upon the recommendation of the sub-committee in charge.

Medical Statistics of South Carolina.

IV. Comparison of General Hospital Beds in the Various Counties of the State with the Federal Standards of Adequacy.

A. M. LASSEK, M.D., PH.D., CHARLESTON, S. C.

The Author:
Dr. Lassek is Professor of Anatomy at the Medical College of the State of South Carolina. He was graduated from the University of Tennessee Medical School (1936) and also holds the degree of Ph.D. from Northwestern University Medical School. He was born in Eau Claire, Wisconsin.

According to the "National Resources Development Report for 1943," 280 new hospitals with 15,550 general hospital beds may be built in needy counties or districts of the U. S. within the next decade or two. Two and one-half billion dollars may be spent on rural sanitation alone. Since mention is made in this federal report that the health record of the southeastern states lags far behind that of other parts of the country, considerable effort and money may be expended in this state. The standard of adequacy of beds for any county or district is considered to be 4.5 per 1,000 people by the federal authorities. Apparently, the federal government is convinced that much of the improvement of the nation's health has been and will continue to be accomplished by the public health service. The new plan, therefore, will revolve around public health units with adequate personnel and clinical facilities in each county or district in the U. S.

The purpose of the present statistical study is to determine as accurately as possible how the various counties of South Carolina compare with the proposed hospital standards of the federal government. If this can be done accurately, then one is in a position to gauge the probable future activity of the public health services in this vicinity, should it materialize. The study is meant to be strictly non-critical and impersonal.

The source of all information is the American Medical Directory of 1942.

RESULTS

If we accept the value of 4.5 general hospital beds per 1,000 population suggested by the federal government as the standard of adequacy, then South Carolina is very inadequately provided with general hospital beds (Table 1). The overall situation shows that there were 4,044 general hospital beds in 1942 distributed to 1,899,804 inhabitants of the state which gives a ratio of one bed to every 470 people or to use the values of the federal government 2.1 beds per 1,000 individuals. This means that South Carolina has only about one-half the suggested amount. The value of 4,044 includes bassinets which amount to 455. It does not include any of the state controlled, army, navy, veteran's administration hospital beds, the private sanitariums devoted to tubercular patients or private special hospitals.

Even more important than the actual number of general hospital beds is their distribution. Sixteen (34.8%) of the counties in South Carolina had no hospitals in 1942. Thirty-two counties had below the state average of 2.1 per 1,000 whereas fourteen exceeded this mean value. Richland county is the only one which exceeds the standard of 4.5 having 5.6 beds per 1,000. All of the other forty-seven counties fall below the adequate, federal standard although Florence county which ranks second practically matches it with 4.3. The specific ratios for the state counties are as follows: Richland, 5.6 general hospital beds per 1,000 population; Florence, 4.3; Charleston, 4.0; Greenville, 3.5; Marion, 3.5; Jasper, 3.3; York, 3.1; Dorchester, 3.0; Spartanburg, 2.8; Greenwood, 2.8; Sumter, 2.5; Berkeley, 2.4; Orangeburg, 2.1; Kershaw, 2.1; Colleton, 2.0; Abbeville, 2.0; Chester, 2.0; Lancaster, 1.9; Darlington, 1.7; Cherokee, 1.6; Newberry, 1.5; Horry, 1.5; Aiken, 1.4; Anderson, 1.4; Oconee, 1.4; Marlboro, 1.3; Williamsburg, 1.3; Laurens, 1.2; Pickens, 1.2; and Union 0.9. The following counties had no general hospital beds in 1942: Allendale, Bamberg, Barnwell, Beaufort, Calhoun, Chesterfield, Clarendon, Dillon, Edgefield, Fairfield, Georgetown, Hampton, Lee, Lexington, McCormick and Saluda. The populations of these counties without hospitals varies from 10,367 to 35,994, the total being 361,534. 19.0% of the population of the state were, therefore, without any general hospital beds.

The number of general hospital beds needed to meet the governmental standards are the following for the various counties of South Carolina: Anderson, 277; Spartanburg, 215; Chesterfield, 162; Lexington, 162; Horry, 158; Aiken, 153; Orangeburg, 153; Laurens, 144; Clarendon, 142; Dillon, 133; Greenville, 132; Williamsburg, 132; Darlington, 125; Pickens, 124; Georgetown, 119; Oconee, 114; Union, 113; Lee, 112; Fairfield, 109; Marlboro, 107; Sumter, 106; Newberry, 100; Beaufort, 99;

From the Department of Anatomy, Medical College of the State of South Carolina, Charleston, South Carolina.

TABLE 1

The financial ranking, population, number of general hospital beds, ratio of beds to population, the minimum number of beds needed according to federal government plans and the surplus or deficit number of beds in each of the counties of South Carolina as of 1942.

County	Financ. Ranking 1939	Pop. 1942	No. Gen. Hosp. Beds 1942	Ratio Beds Per 1,000 Pop.	Minimum Adequate No. Beds Needed	Surplus or Deficit
Richland	1	104,843	583	5.6	472	+111
Florence	7	70,582	301	4.3	318	—17
Charleston	4	121,105	480	4.0	545	—65
Greenville	2	136,580	483	3.5	615	—132
Marion	29	30,107	106	3.5	135	—29
Jasper	41	11,011	36	3.3	50	—14
York	6	58,663	180	3.1	264	—84
Dorchester	34	19,928	60	3.0	90	—30
Spartanburg	3	127,733	360	2.8	575	—215
Greenwood	10	40,083	111	2.8	180	—69
Sumter	17	52,463	130	2.5	236	—106
Berkeley	36	27,128	64	2.4	122	—58
Orangeburg	9	63,707	134	2.1	287	—153
Kershaw	22	32,913	68	2.1	148	—80
Colleton	31	26,268	52	2.0	118	—66
Abbeville	33	22,931	45	2.0	103	—58
Chester	8	32,579	64	2.0	147	—83
Lancaster	20	33,542	62	1.9	151	—89
Darlington	13	45,198	78	1.7	203	—125
Cherokee	16	33,290	54	1.6	150	—96
Newberry	15	33,577	51	1.5	151	—100
Horry	25	51,951	76	1.5	234	—158
Aiken	11	49,916	72	1.4	225	—153
Anderson	5	88,712	122	1.4	399	—277
Oconee	24	36,512	50	1.4	164	—114
Marlboro	26	33,281	43	1.3	150	—107
Williamsburg	28	41,011	53	1.3	185	—132
Laurens	12	44,185	55	1.2	199	—144
Pickens	21	37,111	43	1.2	167	—124
Union	18	31,360	28	0.9	141	—113
Allendale	45	13,040	0	0.0	59	—59
Bamberg	39	18,643	0	0.0	84	—84
Barnwell	35	20,138	0	0.0	91	—91
Beaufort	32	22,037	0	0.0	99	—99
Calhoun	42	16,229	0	0.0	73	—73
Chesterfield	30	35,963	0	0.0	162	—162
Clarendon	43	31,500	0	0.0	142	—142
Dillon	27	29,625	0	0.0	133	—133
Edgefield	40	17,894	0	0.0	81	—81
Fairfield	19	24,187	0	0.0	109	—109
Georgetown	23	26,352	0	0.0	119	—119
Hampton	38	17,465	0	0.0	79	—79
Lee	37	24,908	0	0.0	112	—112
Lexington	14	35,994	0	0.0	162	—162
McCormick	46	10,367	0	0.0	47	—47
Saluda	44	17,192	0	0.0	77	—77
		1,899,804	4,044	Av. 2.1	8,441	—4,397

Cherokee, 96; Barnwell, 91; and Lancaster, 89. Also York, 84; Bamberg, 84; Chester, 83; Edgefield, 81; Kershaw, 80; Hampton, 79; Saluda, 77; Calhoun, 73; Greenwood, 69; Colleton, 66; Charleston, 65; Allendale, 59; Abbeville, 58; Berkeley, 58; McCormick, 47; Dorchester, 30; Marion, 29; Florence, 17; and Jasper, 14. Richland county is the only one having a surplus which amounts to 111.

In 1942, there were forty-four doctors of medicine in the state specializing in public health. They were distributed to twenty-four counties as follows: Richland, 15; Charleston, 2; Florence, 2; Greenville, 2; Greenwood, 2; Georgetown, 2; Spartanburg, 2; Anderson, 1; Aiken, 1; Abbeville, 1; Barnwell, 1; Berkeley, 1; Colleton, 1; Darlington, 1; Dorchester, 1; Edgefield, 1; Horry, 1; Kershaw, 1; Lancaster, 1; Lee, 1; Newberry, 1; Orangeburg, 1; Oconee, 1; and Williamsburg, 1. The remaining twenty-two counties were without public health specialists.

In this study, no close correlation can be made between the number of general hospital beds and county wealth. For example, Jasper county which ranks forty-first financially stands fifth with 3.3 general hospital beds per 1,000 population. On the other hand, Anderson county, which ranks fifth in respect to county wealth, stands well down the

list with only 1.4 general hospital beds per 1,000 people (Table 1).

Other federal or state controlled hospitals in South Carolina which are not included in the present report are the following: United States Navy, 261 general hospital beds; United States Army, 106; South Carolina State Hospital, 4,670 mental beds; State Training School, 859 beds for mentally deficient; South Carolina Sanitarium, 550 beds for tubercular patients; Veterans Administration Hospital, 614 general beds. Privately controlled special hospital beds are as follows: Eye, Ear, Nose and Throat, 15; Orthopedics, 78; Mental and Nervous, 30 and finally 341 tubercular beds.

COMMENTS

If it is assumed that the federal government is anticipating providing an adequate number of general hospital beds and clinical facilities to needy counties or districts in the U. S. within the next decade or two, then one can forecast that considerable building activity either in the way of additions to present hospital facilities or the building of new hospital units may be in prospect for South Carolina. At least forty-four of the forty-six counties in the state are deficient in general hospital beds when they are calculated on the basis of a standard federal ratio to population. Sixteen counties, having 19% of the states population, have no hospitals whatsoever and it is in these that the first steps may be taken to rectify the overall situation. According to the present survey, only 47.3% or 898,607 of our total population could be adequately accomodated with the number of general hospital beds in the state whereas 52.7 or 1,001,196 could not be suitably hospitalized according to the standards of the federal government.

Another factor, which probably cannot be answered at present, is the probable source of medical personnel, if and when, any of the new hospitals are built. What the role of graduates of the state school of medicine may be in such a state health program is speculative.

CONCLUSIONS

1. Sixteen counties in South Carolina have no hospitals or general hospital beds.
2. Only Richland county meets the standard of adequacy of the federal government which is 4.5 general hospital beds for every 1,000 population.
3. According to the proposed standards, there is a deficit of about 4,300 general hospital beds in the state.
4. 52.7% or 1,001,196 people according to federal governmental standards were not adequately supplied with general hospital beds in 1942.
5. Twenty-two counties were without the services of doctors of medicine specializing in public health.
6. If the proposed plans of the federal government materialize, much building activity and an increase in medical personnel can be forecast for South Carolina within the next two decades.

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ALUMNI REFRESHER COURSE

We wish to call the attention of our readers to the program of the Annual Refresher Course which is printed elsewhere in this issue, and we wish to congratulate the committee in charge (Dr. J. I. Waring, Chairman) on the splendid group of speakers who are scheduled to participate in the addresses and discussions.

Although this Refresher Course is sponsored and put on by the Alumni Association of the Medical College, it is open to any physician in South Carolina who wishes to attend. The registration fee for all is $5.00.

We would suggest that every one who is interested mark the dates, November 1, 2, and 3 on his calendar and make his plans to attend. Anyone desiring hotel reservations should make them as early as possible through Dr. H. G. Smithy at the Medical College.

RHEUMATIC FEVER

At one time rheumatic fever was thought to be a rarity in South Carolina. Such is not the belief today and a considerable amount of study is being spent upon the disease in the state. A special survey has been made in the pediatric department of Roper hospital and the results are published in the article by Beach and Ravenel in this issue. Through the Crippled Children Division of the State Board of Health a special Rheumatic Program has been inaugurated, as outlined in the paper by Peeples.

We take pleasure in presenting these two papers and the one by Boone and Levine which deals with another phase of Rheumatic Fever.

HOSPITALS

The statement by Lassek, in his statistical study found elsewhere in this issue, that South Carolina has only about half as many hospital beds as she should have (according to the standard of 4.5 beds per 1,000 population) is one that should make us pause and consider what ought to be done. Certain questions immediately arise in our minds; Can we hope to reach the standard of 4.5 beds per 1,000 population? Do we need that many hospital beds? If more hospital beds are to be built, should it be through the expansion of present hospital facilities or through the erection of new hospitals? Should we consider county or district lines in determining the needs of a given community or area? Are our present hospitals making any plans for post-war additions to their present physical plants? If new hospitals are to be built, who should determine the need and location for these institutions?

These and other questions should be given serious consideration by the members of the Association. Careful studies must be made of the territory which each hospital serves at the present time, of the counties which have no hospitals and of their actual needs. A hospital expansion program developed upon political clamor and expediency will accomplish no good, a program built upon accurate information and a consideration of the actual need will be of immense value. It is essential that our Association be in a position to furnish this information and the views and suggestions of the members of the Association will be welcomed. Each member might well ask himself these two questions: Do my patients have the hospital facilities which they need? If they do not, where should additional hospital beds be built to best meet this need? Having answered the question, the answer should be sent to the Secretary or to Mr. M. L. Meadors, Executive Director and Counsel of the Ten Point Program.

THE SALUDA SEMINAR

Adhering to the principle that it is far more acceptable to pin a flower on a man's coat lapel than it is to place a wreath upon his tomb, we wish to pay tribute to the Pediatric Seminar at Saluda and to its intrepid director and motivating spirit, Dr. D. L. Smith of Spartanburg.

This Seminar which is held in the mountains of North Carolina for two weeks each summer has performed a valuable service to the practicing physicians of the south. For many years the outstanding pediatricians of the south (and in recent years, certain obstetricians) have come to Saluda to give lectures to the general practitioners who attend. The speakers receive no remuneration for their trips except that they are given room and board while in attendance — and yet they come

from as distant points as Florida and Alabama. They speak upon practical subjects in a practical way, and the information which they give is that which is useful in the every-day practice of medicine.

The recent class which assembled in Saluda was one of the largest with over one hundred general practitioners in attendance. Sixteen of these men came from South Carolina. And in spite of the great demands which are being made upon pediatricians for their time, most of the old faculty was there with a few new faces added.

The Seminar should play an even more vital role in the next few years. Many man who are returning from service with the armed forces will want to "brush up" on their pediatrics. We can assure them that they will be welcome and that in our opinion there is no better way for them to spend two weeks. In addition to a streamlined liberal education in the diseases of children, they will find delightful social contacts and an envigorating atmosphere.

The Seminar has been the "brain-child and baby" of Dr. Smith—and to him we wish to say, "You have done a good job, we hope you will be able to continue the good work for many years to come."

DEATHS

JAMES HIGGINS McINTOSH, M.D.
1866-1944

Dr. James Higgins McIntosh died at his home in Columbia September 2, 1944. He was born in Newberry October 3, 1866, and married Miss Frances Nance Baxter also of Newberry, November 2, 1892. Mrs. McIntosh died January 3, 1930. He is survived by three sons and four daughters.

Dr. McIntosh was educated at the local academy in Newberry and Newberry College from which he graduated at 17 years of age. He attended Johns Hopkins from 1884 to 1886, and graduated from the College of Physicians and Surgeons in New York City in 1888. He remained in New York City two years on the staff at Bellevue Hospital, at which time he was also associated with the Society for the lying in. It was largely due to the efforts of Dr. McIntosh while in New York that the original Broome Dispensary became a permanent lying in institution. He then returned to Newberry where he practiced medicine until 1900 at which time he moved to Columbia.

In Columbia Doctor McIntosh held an enviable place in the hearts of his brother physicians. He was always courteous, ethical, kind to the younger members of the profession and punctual to the minute on his consultations. He was a regular attendant of the Columbia Medical Society and where any question of precedent arose his opinion was invariably asked. He was also a guiding hand in the policies of the Tri-State Medical Association. He received many honors, having served as president of the Columbia Medical Society, the 7th District Medical Society, the South Carolina Medical Association, the Tri-State Medical Association and the Association of Surgeons of the Atlantic Coast Line Railway, as Chief of Staff of the Baptist Hospital, and was medical referee for South Carolina for the Mutual Life Insurance Company. During the first World War he served on the local draft board for 18 months, rendering invaluable aid to his country. Dr. McIntosh has been actually engaged in the practice of medicine 56 years, 44 of which have been served in Columbia.

A signal honor came to him in 1942 when the Columbia Medical Society presented him with a handsome silver pitcher and goblets as a token of love and respect. The inscription on the pitcher read:

"In appreciation of the long life spent unselfishly in the service of humanity and as an expression of our friendship and esteem, this token is presented to Dr. James H. McIntosh by his medical colleagues to Columbia, May 20, 1942."

Another token of the high esteem in which he was held generally was the gift by his patients of a fine portrait of Dr. McIntosh which hangs in the lobby of the Columbia Hospital. This was unveiled August 6, 1942.

Dr. McIntosh was the author of many outstanding medical papers, one of the most instructive being, "Drugs Which I have Found Most Useful In My Fifty Years of Practice."

CONNOR JOSHUA MILLER

Dr. C. J. Miller died at his home in Inman on August 21, 1944. A graduate of the Medical College of the State of S. C. (Class 1915), he carried on a large general practice in Inman. He was on the staff of the Spartanburg General Hospital. During 1918, he served for a period in the Armed Forces.

Dr. Miller is survived by his widow, the former Miss Ruth Wilkins.

The Ten Point Program

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

LIFE BEGINS

The Ten Point Program started off on schedule September 1st. The first few days were devoted to rearranging the Association's headquarters so as to make room for and adapt them to the use of the personnel and conduct of the work of the program. Mrs. R. M. Potter, of Florence, was employed as secretary, and, equipped with wholly adequate knowledge and experience, is in a position to render efficient service in that capacity.

To date, necessarily, the work has been devoted to familiarizing ourselves with the general nature of the program and methods of procedure. A large quantity of literature was already on hand in the Association's office, complete files having been maintained by the Secretary on practically all the state and certain other medical journals, the Journal of the American Medical Association, and reports of numerous surveys and studies of interest and importance to the profession.

Letters have been written to key figures in the state concerned with the furnishing of medical care, assuring them of our desire to cooperate with them, and of the absence of any intention on the part of the Association, through the program or otherwise, to interfere with or infringe upon the activities of any established agency.

The preliminary steps have already been taken toward the accumulation of necessary data and material with respect to organizing and operating a statewide hospital service plan. This subject will be among those to receive preferred attention within the next few months.

As a result of the press notices, several commendatory letters have been received from various individuals, and the reaction generally evident is rather encouraging. A few days following the public announcement, an invitation was received from radio station WIS in Columbia to participate in a discussion on its public forum program on Sunday, September 17. To secure all publicity possible throughout the state, a postcard was sent to each member of the Association, telling him of the radio program, asking that he notify several of his non-medical friends of this special feature, with a request that they tune in at the designated time. The broadcast went off as scheduled. Participating were Drs. Hugh Wyman and Gordan Spivey (President and Vice-President of the Columbia Medical Society), the Secretary and the Program Director. Since this is written immediately after the broadcast, it is too early to give a report of what it accomplished.

Your Program Director would be glad to have comments and criticisms from any listener so that further radio presentations may be improved.

HOLLY HILL MEETING

Although the Ten Point Program was not officially inaugurated until September 1, the Secretary and the Program Director had an opportunity to pay their first official visit together at a tri-county meeting in Holly Hill on Wednesday evening, August 30. Some twenty-odd doctors were present from Orangeburg, Bamberg, and Calhoun Counties.

Whatever may be the food situation with respect to rationed items, there ceretainly is no scarcity of fish in Orangeburg County and the adjoining area, and the chef in charge of their preparation in this case was indeed a master of the art. According to a rough estimate, the quantity of delicious fried fish on hand could easily have served a large proportion of the membership of the entire Association. Needless to say then, your Secretary and Program Director spent a delightful evening.

This was true not only because of the meal, however, but because of the opportunity afforded to present the Ten Point Program. This was discussed at length by the Secretary and each of the points was dealt with in some detail, in the effort to give to those present a true picture of the general scheme and of the methods by which we hope to accomplish it.

He then introduced the Executive Director for the program, who was given an opportunity to make a few remarks. He spoke of the high esteem in which the medical profession has been held by the public generally, and of the opportunity presented through the Ten Point Program for the profession once again to justify that esteem and respect, by making a real contribution to the public welfare. The gist of his few remarks was that he believed further talk by him about the program should be postponed until there had been opportunity to get into the work, and begin the effort toward its development. He expressed his appreciation of the opportunity, as a lawyer, to work with the doctors toward such worthy objectives of practical value to the profession and to the public.

Keen interest was shown by those present, and, judging by the reaction during and following the meeting, it is believed that such contacts will be of genuine value in familiarizing the doctors themselves with the scope and purpose of the program, what it means to them and to the public, and of the need for their full cooperation if it is to be made a success. Incidentally, the Secretary received at

the close of the meeting further substantial contributions for the financial support of the program.

An unexpected pleasure was the presence of Colonel Lawrence Thackston, who is on leave from the Army Medical Corps after eleven months service in North Africa and Italy.

Plans are now being made for similar meetings in districts four and nine during the latter part of September, and if the results continue to justify it, an effort will be made to follow the same plan all over the state.

WHAT THE NEWSPAPERS SAY

A release concerning the inauguration of the Ten Point Program was sent to all newspapers for publication September 3. The editors were asked to make editorial comment if they so desired. All the morning papers in the state carried the announcement of the beginning of the Ten Point Program, and several made editorial comment as follows:

Editorial from The State, September 4, 1944

A GOOD MOVE BY THE DOCTORS

"To make good medical care available to all the people of South Carolina at a price commensurate with their ability to pay, to let the people know just what the medical profession and allied agencies have done and are capable of doing for the citizens of South Carolina, to retain the intrinsic American principle of personal initiative and to allow the patient and his doctor freedom of action, and to prevent any political bureau or agency from controlling or dominating the practice of medicine."

That, in epitome, is the Ten Point Program of the South Carolina Medical Association made public through the press of the state yesterday.

That is what the doctors of the state have set out to do, not for themselves, but for the people of South Carolina as a whole. They realize that the present medical "set up" needs revision; they realize certain adjustments must be made and that it is up to the medical men, themselves, to take the lead in these reforms. But they do not propose to go about these changes in a hasty and slipshod way. They expect to conduct a careful survey and from facts and figures to be gathered under the guidance of a competent executive officer, M. L. Meadors, of Florence, to reduce to practical application the Ten Point outline that has been adopted.

The field has not been made narrow. That is one of the fine things about the whole plan. Included are such subjects as care of the indigent, hospital insurance, group health policies, medical and nursing education, the availability of hospital rooms, and so forth. It is an undertaking that shows that the medical profession is alert to present conditions and is anxious to do its part in placing the very best medical care within the reach of all persons without the great financial strain that there is now in so many instances.

Dr. Julian P. Price, of Florence, Secretary of the State Medical Association, has taken the lead in this worthy undertaking. He presented it first to various groups, then to the medical association in annual meeting after approval by the council, seeking, as he went, suggestions on ways and means to improve the outline originally made by him. He not only sought advice but took it and so his final draft is a resume of the combined thought of laymen as well as members of the profession.

THE STATE congratulates the doctors on this progressive move, wishes the program well, and offers its cooperation to make it a success.

Editorial from the Spartanburg Herald, September 5, 1944

BETTER HEALTH

It is generally known that the average person's medical and hospital bill varies according to his income. Well-to-do people spend more for medicine and doctor's bills than poor people.

It follows therefore that when the general economic level of the people is raised they will be able to afford and will consequently avail themselves of more medical care. If we assume further that the more medical care one gets the better his health will be, we can say that in periods of general prosperity the health of the people as a whole is likely to be better than at other times.

Certainly this should be true as regards infant mortality. The South in general has always had a higher infant mortality rate than other more prosperous sections of the country. But the war has brought a measure of prosperity to the average man in the South, a prosperity that is reflected in a sharp decrease in the death of infants.

According to the children's bureau of the department of labor several southern states showed a decline in infant mortality of approximately 20 per cent from 1941 to 1942, while South Carolina showed a decline of 22 per cent. This compares with an average decline of 11 per cent for the nation as a whole.

But we are still behind most of the rest of the nation, and there is much yet to be done. It is encouraging therefore to note that the medical men of this state are advocating a ten point health program, several points in which are designed to give a larger proportion of the population increased medical and hospital care.

From the Florence Morning News, September 3

THE DOCTORS STEP OUT

Elsewhere in this issue is found the announcement, by the South Carolina Medical Association, of the inauguration of a new projcet which is called The Ten Point Program.

The very first point in the program calls for cooperation. The physicians realize that they are not the only ones who are concerned with the health and medical care of the people. The industrialist, the farmer, the labor leader, the business man with employees, the insurance companies, the hospital administrators, the public health official, and the individual who needs medical care—these are those with whom the Medical Association must discuss the question of medical care and these are the ones with whom they must cooperate. We believe that this is what the Association intends to do.

We have heard much about the need of more physicians and of more hospitals in South Carolina but we have never seen any careful and detailed analysis of the question. We are glad to see that such a study is promised.

We are convinced that hospital and health insurance will do much to help the average man meet the unexpected and emergency illness for which he is unprepared. The Medical Association promises to extend the sale of worthwhile insurance and to establish standards by which the companies will be appraised. This is a forward step.

The young men and women of our state have the right to demand the best in medical and nursing education and we will lend our support ot the Medical Association in its efforts to make our Medical College and our various schools of nursing rank with the best in the country.

The last point in the Program deals with the education of the public. For a long time we have felt that the medical profession needed a good publicity agent. It has been our privilege to know many physicians and, by and large, we have found them to be sincere, hard-working men who have the best interests of their communities and of their state at heart. But we have often wondered what they did and what they thought. We have heard them, as a group, oppose a good many plans, but it has been rare to have them present some concrete suggestions as to what would be of benefit to the public. We congratulate them upon their realization of this fact. We heartily endorse their purpose to let the public know what they have been doing, what they are capable of doing, and what they believe will help to raise the standards of medical care in this state.

Reading the entire Ten Point Program, we are impressed with the amount of work and thought which must have gone into its preparation, and with the large amount of work which will be entailed in putting it into execution. The Medical Association has chosen a large task to be performed, but it is a task that needs to be done and we know of no group of men more capable of doing it than the physicians of South Carolina.

All in all, we believe that the South Carolina Medical Association has embarked upon a venture which promises much. We will watch the progress of the Ten Point Program with great interest.

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NEWS ITEMS

The Southern Democratic (Anti-New Deal) Party has announced the names of its eight presidential electors—one of whom is Dr. Strother Pope of Columbia.

Dr. Hal Powe, Jr. (Greenville) has recently been promoted from Lieutenant to Captain. He is now stationed in Italy.

Dr. Kathleen Riley of the University of South Carolina has resigned her position as Resident Physician and is doing postgraduate work at Duke.

Dr. Charles N. Wyatt, formerly of Greenville, is now a full Colonel. He was in Southern Persia when last heard from.

Dr. Capers Smith, son of Dr. Wm. Atmar Smith of Charleston, has been decorated for gallantry in action beyond the call of duty.

Announcement has been made of the arrival of a son, Perry Nelson, to Major and Mrs. Robert Jeanes of Easley, S. C.

Lt. Col. Wilson Ball (Columbia) is now stationed at Yale University, New Haven, Conn.

Dr. and Mrs. J. W. Kitchin of Liberty announce the birth of a daughter. Dr. Kitchin is now in the service.

Dr. I'On Weston, formerly of Columbia and Mullins, has been injured while serving his country in the Pacific area. We hope that his injuries are not serious.

Dr. George T. Peel was the main speaker at the September meeting of the Anderson County Medical Society. His subject was the treatment of burns. Out-of-town guests at the meeting were Dr. W. T. Brockman, Dr. J. B. Parker and Dr. L. H. McCalla, all of Greenville.

Dr. Jackson Frank Wood, a native of Lexington county, has been appointed chief medical officer for the Columbia Veterans administration, succeeding Dr. Henry W. Tobias, who retired and has gone to Washington, D. C.

Doctor Wood, 48, is a graduate of the Medical College of South Carolina in 1922. After interning two years at Roper Hospital, Doctor Wood was engaged in private practice at Ninety Six until 1931, when he entered the medical service of the Veterans' administration.

In November, 1936, Doctor Wood was assigned to the Veterans' administration faculty in Columbia as a staff physician. He was promoted to chief of medical service in 1940 and his new appointment, as chief medical officer, was effective September 2.

PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the Southern Medical Association, Monday, Tuesday, Wednesday and Thursday, November 13-16 — a great wartime meeting. Medical meetings are essential, as essential in wartimes as in peace, even more so. Physicians, civilian and military, need medical meetings. At the St. Louis meeting, a streamlined essential wartime meeting, every phase of medicine and surgery will be covered in the general clinical sessions, the twenty sections, the four conjoint meetings, and the scientific and technical exhibits—the last word in modern, practical, scientific medicine and surgery. Addresses and papers will be given by distinguished physicians not only from the South but from other parts of the United States. Everything under one roof, the Municipal Auditorium.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at St. Louis a program to challenge that interest and make it worth-while for him to attend.

ALL MEMBERS of State and County medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of $4.00 include the Southern Medical Journal, a journal valuable to physicians of the South, one that each should have on his reading table.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
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REFRESHER COURSE

Medical College of the State of South Carolina Tentative Program

Wednesday, November 1, 1944

9:30 A. M. Dr. H. N. Harkins—Treatment of Burns
10:15 A. M. Dr. Bret Ratner—The Allergic Child
11:00 A. M. Dr. G. E. Pfahler—Therapeutic Value of X-ray and Radium for the General Practitioner
11:45 A. M. Dr. A. D. Kaiser—The Tonsil Problem in Children
12:30 P. M.-1:15 P. M. Clinical Cases—Drs. Harkins and Pfahler, Drs. Ratner and Kaiser
1:30 P. M. Luncheon—Medical College Library
(All visitors invited)
Round Table Discussions
3:00 P. M. Drs. Pfahler and Taft—Radiology
Drs. Harkins and Kredel—Surgical Subjects
4:00 P. M. Dr. Kaiser—Rheumatism
Dr. Ratner—Eczema
5:00 P. M. Dr. K. M. Lynch—Pathological Conference

Thursday, November 2, 1944

9:30 A. M. Dr. Paul Titus—Recent Advances in Obstetrics
10:15 A. M. Dr. H. G. Wolff—Headache Mechanisms
11:00 A. M. Dr. H. P. Jenkins — Reconstructive Surgery — Intestinal Obstruction
11:45 A. M. Dr. E. M. Landis—Hypertension Problem
12:30 P. M.-1:15 P. M.
Dr. Titus and Dr. Jenkins—Clinical Cases
Dr. Landis and Dr. Wolff—Psychosomatic Cases
Dr. J. L. Wilson—Chest Cases
Round Table Discussions
3:00 P. M. Dr. Paul Titus—Obstetrics
Dr. H. P. Jenkins—Surgery
4:00 P. M. Dr. Wolff and Dr. Landis—Medicine—Headache — Differential Diagnosis and Management
5:00 P. M. Dr. J. L. Wilson—The Part of the Doctor and the Hospital in the Coming Control of Tuberculosis
8:00 P. M. Banquet—Founders Day
Speaker — Dr. Victor Johnson, Associate Professor of Physiology, University of Chicago, Secretary of the Council of Medical Education and Hospitals, American Medical Association
"Medicine After The War"

Special Session on Physical Medicine

Friday, November 3, 1944

Stark General Hospital Medical Library — (Transportation furnished)
Program: 10:00 A. M.-10:30 A. M. Tour of Hospital and Physical Therapy Clinic
Scientific Program: 10:30 A. M.-1:00 P. M.
Dr. Jaqua (Baruch Foundation) will speak
1. Address of Welcome—Col. W. W. Vaughan, MC. Commanding Officer, Stark General Hospital, Charleston, S. C.
Physical Medicine and War Injuries:
Charles H. Fair, Lt. Col., MC. Chief Surgical Service
John G. Reid, Maj., MC. Chief, Orthopedic Section
Arthur M. Pruce, Capt., MC. Chief Physical Therapy Section
2. Amputations: Methods and technics in combat zones
Revision, after care and rehabilitation.
Demonstration—Major Reid and Captain Pruce
3. Peripheral Nerve Injury: The role of splinting and Physical Therapy in pre and post operative care.
Demonstration.
a. Electro diagnosis—Lt. Elizabeth Kelly, P. T. A.
b. Presentation of typical nerve injuries and splints—Captain Pruce
Luncheon 1:00 P. M. Officers Mess

The list of speakers for the Refresher Course is as follows: (the titles for their papers have not yet definitely been decided).

Dr. Hilger Perry Jenkins, Surgeon, Associate Professor of Surgery at the University of Chicago, author of "A Terminology of Operations of the University of Chicago Clinics," and numerous papers. Dr. Jenkins has often visited relatives in Columbia.

Dr. Albert David Kaiser, Pediatrician, author of "Childrens Tonsils in or out," Associate Professor of Pediatrics at Rochester University and on the Advisory Committee of the Children's Bureau, (American Academy of Pediatrics).

Dr. Eugene Markley Landis, Physiologist, former Professor of Internal Medicine at Virginia and now the George Higginson Professor Physiology at Harvard. In 1942 he was president of the Society for Clinical Investigation. He is co-author of a monograph entitled "Hypertension."

Dr. Bret Ratner, Allergist, Associate Attending Physician of the Children's Division, Bellevue, Attending Allergist, Seaside Hospital, Staten Island and Clinical Professor of Pediatrics at N. Y. U., author of "Allergy, Anaphylaxis and Immunotherapy," (1943).

Dr. Harold George Wolff, Internist, formerly Assistant Psychiatrist at Johns Hopkins Medical School, now Associate Professor at Cornell and Associate Attending Physician, New York Hospital. His specialties are neurophysiology and psychosomatic medicine.

Dr. George Edward Pfahler, Radiologist, Philadelphia, author of a monograph on the "Roentgen treatment of cervical adenitis," and The Diagnosis and Treatment of Tumors of the Bladder." He is a past president of the Roentgen Radium Society, the Physical Therapy Association and College of Radiologists.

Dr. Paul Titus, Obstetrician, president of the Executive Council of the American Association of Obstetrics, Gynecology and Abdominal Surgery secretary of the American Board of Obstetrics and Gynecology and the author of an "Atlas of Obstetric Technic," and "Management of Obstetric Difficulties."

Dr. Henry N. Harkins, Surgeon, Associate Professor of Surgery at Johns Hopkins, is Editor-in-chief of the Quarterly Review of Surgery and author of "Treatment of Burns."

Dr. Julius Lane Wilson, Associate Professor of Medicine at Tulane, Secretary-Treasurer American Trudeau Society — Charity Hospital Staff.

PRELIMINARY PROGRAM REFRESHER COURSE

Organized by the S. C. Society Ophthalmology and Otolaryngology
October 31, 1944

9:00 P. M. Reception for visiting Speakers and Guests

November 1, 1944 (*Titles to be announced later*)
9:00 A. M. Henry M. Goodyear, Cincinnati, Ohio
11:00 A. M. Dr. James S. Shipman, Philadelphia, Pa.
1:30 P. M. Luncheon—Medical College Library
3:00 P. M. Dr. James Watson White, New York

4:30 P. M. Dr. Oscar V. Batson, Philadelphia, Pa.
6:00 P. M. Adjournment
8:00 P. M. Smoker to be given by South Carolina Society Ophthalmology and Otolaryngology

November 2, 1944

9:00 A. M. Dr. Batson
10:30 A. M. Dr. White
12:00 Noon (Lenses and Their Application) Mr. Scott Sterling, Bausch & Lomb Scientific Staff
1:00 P. M. Luncheon—St. Francis Infirmary
3:00 P. M. Dr. Goodyear
4:30 P. M. Dr. Shipman
6:00 P. M. Adjournment
8:00 P. M. Founders Day Banquet

MEDICAL COLLEGE NEWS

At the commencement exercises of the Medical College, at which Dr. Herman B. Baruch, President of the Baruch Foundation for Medical Research, New York, was the principal speaker, the following men received the degree of Doctor of Medicine:

SENIOR MEDICAL CLASS

January 3, 1944-September 16, 1944

1. Bailes, L. C.—Anderson, S. C.
2. Bates, G. W., Jr.—Charleston, S. C.
3. Boatwright, H.—Seneca, S. C.
4. Boyter, H. H.—Woodruff, S. C.
5. Brill, H. H.—Columbia, S. C.
6. Brockman, H. L., Jr.—Greer, S. C.
7. Brooks, W. E.—Charleston, S. C.
8. Bryan, W. M., Jr.—Columbia, S. C.
9. Chapman, W. S.—Florence, S. C.
10. Cline, L. M., Jr.—Greenville, S. C.
11. Collins, S. L.—Batesburg, S. C.
12. Dennis, L. B., Jr.—Florence, S. C.
13. Estridge, M. N.—Rock Hill, S. C.
14. Fincher, R. C., Jr.—Union, S. C.
15. Frierson, J. H., Jr.—Charleston, S. C.
16. Galloway, J. B.—Spartanburg, S. C.
17. Garland, N. F.—Columbia, S. C.
18. Gazes, P. C.—Charleston, S. C.
19. Ghent, T. D.—Lancaster, S. C.
20. Hamilton, W. H., Jr.—Hemingway, S. C.
21. Hanna, C. B.—Enorec, S. C.
22. Harper, R. D.—Andrews, S. C.
23. Hester, L. I., Jr.—Mount Carmel, S. C.
24. Jones, A. P.—Moultrieville, S. C.
25. McLawhorn, W. R., Jr.—Greenville, S. C.
26. McCoy, E. G.—Sumter, S. C.
27. Montgomery, B. M.—Kingstree, S. C.
28. Moore, M. P., Jr.—Charleston, S. C.
29. Nettles, J. B.—Columbia, S. C.

(Continued on page 218)

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30. Paulling, R. M., Jr.---Mt. Pleasant, S. C.
31. Pickett, O. M.---Sullivan's Island, S. C.
32. Penton, J. R., Jr.---Montgomery, Ala.
33. Pitts, J. W.---Columbia, S. C.
34. Pringle, R. A.---Charleston, S. C.
35. Prystowsky, Rose P.---Charleston, S. C.
36. Prystowsky, Milton---Charleston, S. C.
37. Rawl, A. E., Jr.---Navy Yard, S. C.
38. Rhame, J. M.---Sumter, S. C.
39. Riddle, H. D.---Columbia, S. C.
40. Ross, H. G.---Columbia, S. C.
41. Shecut, J. C.---Orangeburg, S. C.
42. Skinner, C. B.---Hartsville, S. C.
43. Smith, H. B., Jr.---Mullins, S. C.
44. Stiff, A. O.---St. Stephens, S. C.
45. Thomas, B. D.---York, S. C.
46. Thomas, J. D., Jr.---Loris, S. C.
47. Wooten, E. L.---Camden, S. C.
48. Workman, J. A.---Woodruff, S. C.

CORRESPONDENCE

September 4, 1944

Dr. Julian P. Price
Secretary-Editor
South Carolina Medical Association
Florence, South Carolina

Dear Dr. Price:

Permit us to comment further upon the question raised in the correspondence published in the June issue of the Journal.

The action of the council as set forth in the letter signed by Dr. Cain as Chairman apparently is based upon the failure to find any constitutional provision for combining the position of delegate to the American Medical Association with the office of secretary; and by finding, presumably by investigation, "that Dr. Hines was elected a delegate in 1911 *and at other times*" (italics ours).

After reading this letter, although convinced that our position was correct, one of us re-read the minutes from 1908 through 1940 and failed to find a single reference to the election of Dr. Hines "at other times" than in 1911. It seems evident therefore that the Council had made no investigation or had read the minutes most casually. Such a method of disposing of a basic parliamentary question which had been raised seriously by two ex-presidents who through many years of service have demonstrated their deep interest in the Association and in the medical profession was profoundly disappointing.

With regard to the meaning of Dr. Cheyne's phraseology, you will find upon reference to his report that the clause "not at all in a presumptuous way but as entirely a matter for your serious consideration" is included between commas which shows that it is a subsidiary clause. The main clause reads, "I beg to make the suggestion — that the Secretary of the South Caroina Medical Association be one of these delegates," etc. The subsidiary clause was introduced to explain that he was not making the suggestion presumptiously but for serious consideration. That the House of Delegates did consider it seriously and regarded the adoption of the report as establishing a new rule of action or, speaking technically, a Standing Rule, is shown by the immediate election of Dr. Cheyne "delegate ex-officio," and by their failure to elect Dr. Hines a delegate in addition to electing him secretary through the many years of his service with the exception of 1911 when in response to his request, the rule was suspended, not rescinded. Any other interpretation would mean that the House of Delegates did not know what they were doing and did not find out until after Dr. Hines' death in 1940. This, we submit, is a *reductio ad absurdum*.

As to the constitutional question, the Council should know that a rule of action does not have to be in the by-laws or in the constitution to make it binding. Nor does a report have to be discussed or referred to a committee to make its adoption legal. The adoption of a report, whether immediately without discussion, or later after mature consideration, includes the adoption of every suggestion, recommendation or resolution contained in it. The adoption of Dr. Cheyne's report therefore established a new Standing Rule governing the election of delegates to the American Medical Association, and the Council exceeded its authority in changing the method of appointment or election. Furthermore, the Council also exceeded its authority in making any appointment except that of secretary and editor of the Journal and assistants. Chapter VII of the constitution in force in 1940 is explicit. It gives the "authority to appoint an editor and such assistants as it deems necessary" and, "In the event of a vacancy in the office of the secretary or of the treasurer, the Council shall fill the vacancy until the next annual election." According to the constitution, no other office could be filled by the Council.

If the Council, or even the House of Delegates, can disregard arbitrarily a regulation established by unanimous action, what is the use of a constitution, or by-laws, or rules of order? It is too serious a matter to drop lightly.

For our information will you please specify in the columns of the Journal the "other times" when the Council found that Dr. Hines was elected, and will you also explain how the Council interpreted the statement that Dr. Cheyne and later Dr. Hines, was named delegate *ex-officio*?

Respectfully,
Robert S. Cathcart, M.D.
Robert Wilson, M.D.

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Camp Forrest, Tenn.
19 September, 1944

Dr. Julian P. Price
Florence, S. C.
Dear Dr. Price:

I read the article entitled "Straight Talk," in the August Issue of the Journal, and though one should probably avoid arousing any "rub" between the Army and Navy (except on the gridiron), I must say that I could not agree with the very obvious "attitudes" expressed in the article.

Today I have just finished reading through the September issue of the Journal, and I am happy to have found what I would term, "Just What The Doctor Ordered," in the way of a reply to "Straight Talk."

I therefore desire to express my appreciation to these good South Carolina Doctors (Drs. Guess and Jervey), for having taken the time and effort from their busy practices, to state in such fine manner, some facts and comments which seem most appropriate regarding the above article.

While in the service, I have not gone around, "polling" my associates in the profession (in the Army) on post war problems and their respective "attitudes," but in fairness to all of us, I frankly have not heard such opinions expressed or inferred during this rather extended "tour of duty" which I am now serving. And though my opinion has not been solicited, I feel the urge to volunteer an opinion, based on contacts over these last few years, with a considerable number of medical officers, that "Straight Talk" does not express the "attitudes" of the great majority of those of us, who have at present the privilege of serving, away from home. I further sincerely trust, that if and when we are able to return to our former homes, that our friends in the profession will not have "Straight Talk" in their minds, when they greet us.

Very truly yours
Robert P. Jeanes,
Major M. C. A. U. S.

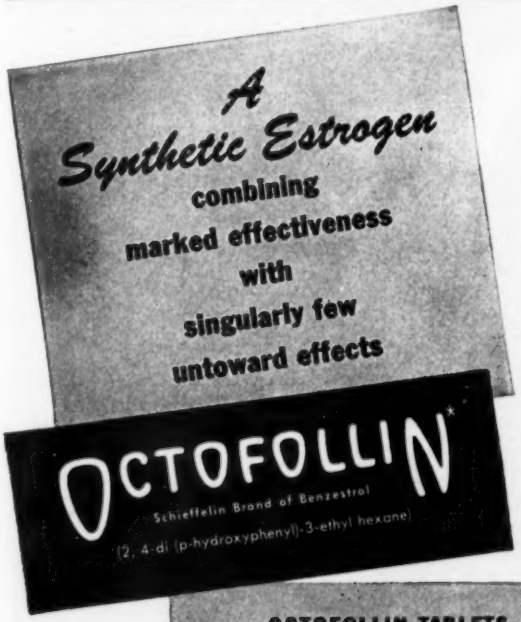
AERO SAKOS

This column was shunted to the sidelines last month because Julian Price said we could only print the essentials. Of course my staff immediately attempted to have one of the Governmental agencies reprimand Julian, but to date we have not heard from that agency.

One story that is both interesting and informative comes to us by the usual route. We stole it from some other publication. It seems that the otolaryngologist, try as he would, had been utterly unable to improve the womans voice, which was practically inaudible. Believing that the trouble was purely functional, he decided to make an experiment.

First, he ordered the patient to bed. Then, taking along several colleagues who were familiar with the case, he went to see her — leaving the other physicians downstairs while he proceded to the sickroom. There he informed the woman that he was going to try a new treatment — one that would require him to work in the nude.

Aghast, the patient objected in a hoarse whisper, saying that she never heard of such a thing. Nevertheless, the doctor proceded to do a strip-tease—removing first his vest, then his shirt, then his trousers. When he started to take off his underwear, the woman let out a wild scream. "Get out of here," she yelled, "or I'll call the police. . . Help!"



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The other physicians came up the stairs on the run—to find the otolaryngologist smiling happily and able at last to announce the cure of a classic case of hysterical laryngitis.

Another story told by a hunter friend of mine and vouched for by others is the following. The members of a hunting party had been specifically requested to bring only male hounds. One member, however, owned only a bitch hound, and out of courtesy was finally permitted to include her. The pack was off in a flash. In a matter of seconds they were completely out of sight. The confused hunters stopped to question a farmer in a nearby field. "Did you see some hounds go by here?" "Yep," said the farmer. "See where they went?" "Nope," was the reply, "but it was the first time I ever saw a fox running fifth!"

In this column we have always contended that the physicians were the chosen few. We have never gone into any enthusiastic spasm over this statement but each time we read an account such as the following we know we are right.

A Harvard man enlisted in the United States Army as a private. He had been in the service about three weeks when his captain posted a notice on the bulletin board. The Harvard man read it and sniffed. "It is pretty hard," he told another soldier "to take orders from a man who knows no better than to end a sentence with a preposition." The captain overheard him. Next day the bulletin carried this notice: "There is a certain amount of insubordination up with which I shall not put."

Or we might remember the story of Isodora Duncan, the famous dancer and George Bernard Shaw, the wit. It seems that this pair met in London and Miss Duncan proposed marriage to Mr. Shaw. "Think what a wonderful thing it would be to have a daughter with my grace and your brains," said Miss Duncan. "That would be fine," answered Mr. Shaw. "But suppose such a daughter were to have your brains and my grace!"

Or suppose we were to have in our profession such men as the following: Working in a munitions factory, a man let his coat get caught in a revolving wheel. He was whisked round and round till the foreman managed to switch off the machine. The workman fell to the ground and up rushed the foreman. "Speak to me, speak to me," he said. "Why should I?" said the workman. "I passed you six times just now, and you didn't speak to me!"

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